

requirements described in § 423.505(e)(1)(iii).

[70 FR 4525, Jan. 28, 2005, as amended at 73 FR 54251, Sept. 18, 2008; 74 FR 1543, Jan. 12, 2009]

§ 423.48 Information about Part D.

Each Part D plan must provide, on an annual basis, and in a format and using standard terminology that CMS may specify in guidance, the information necessary to enable CMS to provide to current and potential Part D eligible individuals the information they need to make informed decisions among the available choices for Part D coverage.

§ 423.56 Procedures to determine and document creditable status of prescription drug coverage.

(a) *Definition.* Creditable prescription drug coverage means any of the following types of coverage listed in paragraph (b) of this section only if the actuarial value of the coverage equals or exceeds the actuarial value of defined standard prescription drug coverage as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines.

(b) *Types of coverage.* The following coverage is considered creditable if it meets the definition provided in paragraph (a) of this section:

(1) Prescription drug coverage under a PDP or MA-PD plan.

(2) Medicaid coverage under title XIX of the Act or under a waiver under section 1115 of the Act.

(3) Coverage under a group health plan, including the Federal employees health benefits program, and qualified retiree prescription drug plans as defined in section 1860D-22(a)(2) of the Act.

(4) Coverage under State Pharmaceutical

Assistance Programs (SPAP) as defined at § 423.454.

(5) Coverage of prescription drugs for veterans, survivors and dependents under chapter 17 of title 38, U.S.C.

(6) Coverage under a Medicare supplemental policy (Medigap policy) as defined at § 403.205 of this chapter.

(7) Military coverage under chapter 55 of title 10,

U.S.C., including TRICARE.

(8) Individual health insurance coverage (as defined in section 2791(b)(5) of the Public Health Service Act) that includes coverage for outpatient prescription drugs and that does not meet the definition of an excepted benefit (as defined in section 2791(c) of the Public Health Service Act).

(9) Coverage provided by the medical care program of the Indian Health Service, Tribe or Tribal organization, or Urban Indian organization (I/T/U).

(10) Coverage provided by a PACE organization.

(11) Coverage provided by a cost-based HMO or CMP under part 417 of this chapter.

(12) Coverage provided through a State High-Risk Pool as defined under 42 CFR 146.113(a)(1)(vii).

(13) Other coverage as the Secretary may determine appropriate.

(c) *General disclosure requirements.* With the exception of PDPs and MA-PD plans under § 423.56(b)(1) and PACE or cost-based HMO or CMP that provide qualified prescription drug coverage under this Part, each entity that offers prescription drug coverage under any of the types described in § 423.56(b), must disclose to all Part D eligible individuals enrolled in or seeking to enroll in the coverage whether the coverage is creditable prescription drug coverage.

(d) *Disclosure of non-creditable coverage.* In the case that the coverage of the type described in § 423.56(b) is not creditable prescription drug, the disclosure described in paragraph (c) of this section to Part D eligible individuals must also include:

(1) The fact that the coverage is not creditable prescription drug coverage, as provided by CMS;

(2) That there are limitations on the periods in a year in which the individual may enroll in Part D plans; and

(3) That the individual may be subject to a late enrollment penalty, as described under § 423.46.

(e) *Disclosure to CMS.* With the exception of PDPs and MA-PD plans under § 423.56(b)(1) and PACE or cost-based HMO or CMP that provide qualified prescription drug coverage under this Part, all other entities listed under